

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6177 62-025305
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

FILED JUL 2 1962

VS 300
Rev. 4/59

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USE BLACK INK
OR
TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b	c. CITY OR TOWN Lemay Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Barnes Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 105a Waller Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED First Middle Last James F. Walsh			4. DATE OF DEATH Month Day Year June 19, 1962
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1936
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemical Worker		10b. KIND OF BUSINESS OR INDUSTRY Natl. Lead Co.	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME Stephen B. Walsh		13b. MOTHER'S MAIDEN NAME Margaret Webb	14. NAME OF HUSBAND OR WIFE Carolyn Walsh
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	17. INFORMANT Address Carolyn Walsh 105a Waller Lemay, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bilateral; Toxic Nephritis; secondary to extensive burns; 70% of body; suffered when burned while working at National Lead Company; St. Louis County, when flange on steam line ruptured about 11:00 A.M. on June 12, 1962. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) St. Louis County, when flange on steam line ruptured about 11:00 A.M. on June 12, 1962. DUE TO (c) ACCIDENT			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ACCIDENT			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) see above	
20c. TIME OF INJURY Hour a.m. p.m. 11:00 Month, Day, Year 6-12-62		20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) factory		20f. CITY, TOWN, OR LOCATION St. Louis County, Mo	COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 11:05 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Helen L. Taylor Coroner		22b. ADDRESS 1300 Clark Ave.	22c. DATE SIGNED 6-21-62
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 6-22-62	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cem.	23d. LOCATION (City, town, or county) (State) Lemay, Mo.
24. FUNERAL DIRECTOR ADDRESS Southern Funeral Home 5322 S. Grand, St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. JUN 21 1962	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed James O. Hill

Licensed Embalmer No. 4347

P. O. Address 6322 Do Grant

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license)

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.